

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN2707</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/14/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>NHC HEALTHCARE, MILAN</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8017 DOGWOOD LANE P O BOX A MILAN, TN 38358</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 002	1200-8-6 No Deficiencies  This Rule is not met as evidenced by: During the annual re-licensure survey conducted on 12/13/10 through 12/14/10 NHC Healthcare -Milan was found to be in compliance with the state licensure regulations..	N 002			

Division of Health Care Facilities

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

614Z11

If continuation sheet 1 of 1